STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Bremerton SCC LLC
The Arbor at Bremerton
3510 9th Street
Bremerton, WA 98312

RE: The Arbor at Bremerton License # 2619

Dear Administrator:

This letter addresses Compliance Determination(s) 36165 (Completion Date 01/31/2024) and 33451 (Completion Date 12/14/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/31/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2703-4-a

The Department staff who did the on-site verification:
Michael Goulet, Complaint Investigator

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit D
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: The Arbor at Bremerton
Provider Type: Assisted Living Facility
License/Cert.#: 2619
Compliance Determination #: 33451
Intake ID: 108839
Investigator: Michael Goulet
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 12/05/2023 through 12/14/2023
Complainant Contact Date(s): 12/05/2023, 12/14/2023

Allegation(s):

1) Residents with sores due to not being changed (no resident named)
2) No trash bags or wipes available
3) Med techs refuse to give soap to staff
4) Severe staff issue (no details provided)
5) Room door lock broken and staff cannot enter room
6) Resident has compound fracture from husband
7) Resident fell and staff could not open door, resident had to crawl to door (see #5 above)
8) Resident smashed out a window and ran out of facility, brought back by staff coming to work
9) Resident died and had not been checked on for 15 hours (no name, date or details provided)
10) Resident left facility due to door not being re-set by staff
11) Resident "cracked someone's head open" (no resident named, no date or details provided)
12) Resident attacks staff because his medication is not correct, and staff do not care for the resident at night due to this behavior
13) One caregiver in facility, one med tech between both facilities
14) Call light system does not work
15) Residents not showered, leading to skin breakdown

Investigation Methods:

Sample:
Total residents:
Resident sample size: 31
Closed records sample size: 1

Observations:
General environment
Resident Condition
Residents in their rooms
Staff to resident interactions
Resident to resident interactions
Availability of food, supplies, utilities, etc.

Interviews:
Residents
Staff
Collateral Contacts

This document was prepared by Residential Care Services for the Locator website.

Record Reviews: Facility Progress Notes (3)
Resident Care Plans (2)
Staffing Schedule

Investigation Summary:

1, 15) Per direct observation of skin conditions of residents named as having sores/ skin breakdown by complainant, there were no significant issues noted. One resident did have a rash under their breasts related to a yeast infection for which they are administered medication, and another resident was noted to have a small spot of redness to their coccyx area, but no resident was noted to have any actual pressure ulcer. Close observation of multiple residents in the facility (31) did not reveal any lack of appropriate bathing or incontinence care, and all residents were observed to be clean and in clean clothing with no odor of unattended incontinence issues noted in the facility.
2) Trash bags and sanitary wipes were noted to be available in resident rooms.
3) No indication per the observation of residents that soap was not available for use by staff. Per facility resident care coordinator (RCC), staff do keep liquid soap/ shampoo, etc. locked away from residents so that residents do not attempt to drink these items, but there was no indication that these items are kept from being used.
4, 13) No lack of staffing was noted during facility visit, and no lack of appropriate care was noted per direct observation of multiple residents. Per interview with resident family members, no complaint of any lack of care was noted. Record review of facility staffing shcedules for December 2023 showed that three to four staff are scheduled for morning shift, two to three staff are scheduled for evening (PM) shift, and two staff are scheduled for overnight (NOC) shift.
5, 7) Observation of the lock for the room of residents 1 and 2 showed that there was no key cylinder (the part that the key fits into) in the lock, and that the door could not be opened from the outside if locked from the inside by the residents. Staff stated that this door lock had been in this condition "for months". The male resident stated that they had fallen in their room, and that staff were not able to enter to assist the resident, leading to the resident having to crawl on the floor and open the door for staff. Staff had also previously stated concerns that the male resident had physically abused the female resident (their spouse; this was investigated previously and was not able to be substantiated) and that the residents had been moved to this room for increased monitoring by staff (as the room is across from the nursing station), and so that staff could intervene in the event of an altercation. This issue was cited as per WAC 388-78A-2703 (4a) Safety of the Built Environment.
6) The resident referred to is the female resident noted in #5 above. The resident did suffer a fractured finger, but the cause of this injury was not determined as no altercation was witnessed, with only yelling by the female resident being noted prior to the injury being noted by staff. It is possible that the injury was related to a fall and not to any action on the part of the resident's spouse.
8) Per staff interview, the resident broke out a window in another resident's room and left the facility, but was seen by staff and returned without harm. The resident was sent out to hospital for evaluation and was transferred by the hospital to a [redacted] facility. From prior interview of the resident, it was noted that there may have been some underlying mental illness issues for the resident that had not been diagnosed prior to the resident's admission to memory care, and it would appear that the hospital evaluation of the resident supported this observation. Per staff, the resident will not be returning to the facility.
9) Per interview with the staff member who was stated by the complainant as initially reporting this issue, the resident in question was not from this facility or from their sister facility (Arbor assisted living), but from a third facility (Laurel Glen, now Vineyard Park). This allegation was referred to the investigator overseeing that facility.
10) Per staff interview, the resident did not leave the facility grounds and was found by

This document was prepared by Residential Care Services for the Locator website.

staff in the fenced courtyard behind the facility and returned without harm. The resident stated no memory of having left the facility.
11) Per staff interview and per record review of facility progress notes for the resident, there was no indication of the resident injuring any other resident or staff member. Two resident to resident altercations were noted, one in which the resident pushed another resident out of their room, and one where the resident was yelling at a peer and a third resident attacked the named resident. No harm was noted to have occurred in either instance. Per facility progress notes and the named resident care plan, the resident was noted to be irritable and verbally abusive, but not noted to initiate physical altercations. This was supported by interview with the named resident.
(continued in Activities due to lack of space)

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

This document was prepared by Residential Care Services for the Locator website.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2619	Compliance Determination # 33451
Plan of Correction	The Arbor at Bremerton	Completion Date
Page 1 of 3	Licensee: Bremerton SCC LLC	12/14/2023

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 12/05/2023 and 12/05/2023 of:

The Arbor at Bremerton
3510 9th Street
Bremerton, WA 98312

This document references the following complaint number(s): 108839

The following sample was selected for review during the unannounced on-site visit: 31 of 0 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Michael Goulet, Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

_____ 12/19/2023
Residential Care Services Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies	License #: 2619	Compliance Determination # 33451
Plan of Correction	The Arbor at Bremerton	Completion Date
Page 2 of 3	Licensee: Bremerton SCC LLC	12/14/2023

Melissa Smeer
Administrator (or Representative)

12/22/23
Date

WAC 388-78A-2703 Safety of the built environment. The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards, including:

(4) Providing door hardware to ensure:

(a) Residents cannot lock themselves in, or out of, rooms or areas accessible to them; and

This requirement was not met as evidenced by:

Based on observation and interviews, the assisted living facility failed to ensure that 2 of 8 sampled residents' (Residents 1 and 2) room door lock functioned as intended, leading to staff not being able to enter the residents' room from the outside to assist the residents in the event of a fall or other concern. This failure placed the residents at risk of physical harm.

Findings Included...

During an interview on 12/05/2023 at 10:30am, Staff A (Resident Care Coordinator, RCC) stated that the door lock for Residents 1's and 2's (R1 & R2) room was broken, leading to staff not being able to enter the room if the door was locked from the inside by either of the residents. Staff A stated that this had been an issue known to facility staff "for months," and was unable to state why the issue had not been addressed previously.

Observation on 12/05/2023 at 11:00am of the door lock for the room of R1 & R2 showed that the lock cylinder (the part into which the key fits) was missing, and that if the door was locked there was no way to open it from the outside.

During an interview on 12/05/2023 at 11:05am, R1 stated that they had fallen in their room and staff were not able to enter to assist the resident. R1 stated that they had to crawl to the door to allow staff to enter after this fall.

Plan/Attestation Statement

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies	License #: 2619	Compliance Determination # 33451
Plan of Correction	The Arbor at Bremerton	Completion Date
Page 3 of 3	Licensee: Bremerton SCC LLC	12/14/2023

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Arbor at Bremerton is or will be in compliance with this law and / or regulation on (Date) 12/6/2023 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Melissa Smeer — Administrator (or Representative)

12/22/23 — Date

This document was prepared by Residential Care Services for the Locator website.